

DENTIST AND DENTAL AUXILIARY PERSONNEL VOLUNTEER APPLICATION

COMPLETE & MAIL, FAX OR E-MAIL TO:
The Maryland State Board of Dental Examiners
Spring Grove Hospital Center / Benjamin Rush Building
55 Wade Avenue / Tulip Drive
Catonsville, Maryland 21228
Phone: 410-402-8500 Fax: 410-402-8505
E-mail: dentalvolunteers@dhmh.state.md.us

Yes, I would be willing to volunteer my time to provide dental care in an emergency situation.

Name: _____
Please Print License No. Exp. Date

Health Occupation: ☐ Dentist ☐ Dental Hygienist ☐ Dental Radiation Technologist

Specialty (if any): _____

CONTACT INFORMATION:

Pager: _____ Cell: _____ Fax: _____

Home Phone: _____ Work Phone: _____

Email (business/personal): _____

Name of Practice: _____

Street Address: _____

County: _____ City: _____ State: _____ Zip: _____

Home Address: _____

County: _____ City: _____ State: _____ Zip: _____

*Please indicate how you should be contacted in the event of an actual emergency:
_____.

*Please list below the counties you are willing to serve in or whether you are willing to serve Statewide and / or Nationally:
_____.

TRAINING, EXPERIENCE AND SKILLS:

*Please check any of the following areas in which you have training or experience:

☐ Chemical Agents ☐ Forensic Dentistry ☐ Biological agents
☐ Decontamination and infection Control ☐ Advanced Life Support ☐ Basic First Aid

*Please list language skills, including American Sign Language:

_____ ☐ speak ☐ read ☐ write
_____ ☐ speak ☐ read ☐ write

*Please tell us about any other skills that you may have which would be useful in an emergency:

*For Dentists:

I am willing to permit the use of my dental office to supplement hospital facilities? ☐ Yes ☐ No